PLEASE DELIVER THE ENCLOSED REPORT AND INSTRUCTION BOOKLET IMMEDIATELY TO THE PERSONNEL DEPARTMENT.

INSTRUCTIONS FOR COMPLETING THE GROUP HEALTH PLAN REPORT FOR THE IRS/SSA/CMS DATA MATCH

NOTICE TO EMPLOYERS:

- The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration, is the Federal agency responsible for administering the Medicare and Medicaid programs.
- You are required by law {42 USC 1395y(b)(5)} to complete this report. The law requires you to complete this report within 30 days of receipt. Failure to complete this report timely or accurately could lead to the imposition of a civil monetary penalty.
- CMS understands that the Data Match Project will prove burdensome to some employers, but we strongly believe the money saved and recovered from this project far outweighs the burdens.
- Completion of the Data Match Questionnaire benefits employers, Medicare beneficiaries covered by the employer's group health plans, providers of medical services to Medicare beneficiaries and the Medicare program. The employer benefits because medical claims involving Medicare beneficiaries covered by group health plans are received and processed more timely which reduces administrative expenses and provides better services to covered individuals. Covered Medicare beneficiaries benefit because their claims are processed correctly in the first instance. In almost all instances where Medicare is a secondary payer to a group health plan, the beneficiaries out of pocket expenses are lower than they would be otherwise. The Medicare Program benefits because Medicare makes fewer mistaken primary payments; which reduces the trust fund expenses and the administrative cost of attempting to collect inappropriate payments. In addition, providers, physicians and other suppliers benefit because the total payments they receive for services provided to Medicare beneficiaries are greater when Medicare is a secondary payer to a group health plan than when Medicare is the primary payer.
- Please review the instruction booklet for discussion of the reasons why we are requesting this information and about how you can obtain an extension if you need more than 30 days to complete this report.
- If you are interested in an alternative way in processing of the Data Match paper questionnaire, turn to page 11 for information on the voluntary data sharing agreement.
- If you are required to complete questionnaires on less than 500 workers, please turn to page 10 of this booklet for the information regarding our Electronic Bulletin Board Service.
- Please make a copy of the completed questionnaire for your records and return the completed **original** to the address specified below.

ADDRESS:
MEDICARE – Coordination of Benefits
IRS/SSA/CMS Data Match Project
PO Box 125
New York, NY 10274-0125

TELEPHONE:
1-800-999-1118
or (TTY/TDD): 1-800-318-8782

Website: www.hcfa.gov/medicare/cob

IRS/SSA/CMS DATA MATCH QUESTIONNAIRE

Quick Reference Guide for Employers

General Instructions: Please enter all dates in MM/DD/CCYY format. Please type or print legibly using black ink **(Please do not use markers)**. After completing the questionnaire, make a copy for your records and return the original to the address specified. For further information and assistance in completing the Group Health Plan Report, please call our toll-free number: **1-800-999-1118 or (TTY/TDD): 1-800-318-8782. Please do not staple the returned questionnaire.**

Questionnaire Part I

- If you answer "NO" to both *Questions 1a and 1b*, **DO NOT** answer any of the other questions in Part I, II, or III. **Proceed to Part IV and fill in the Certification information. Then return Part I, Page 1, and Part IV using the self-addressed label or envelope provided.** *For an example, see page 14 of this booklet.*
- If you answer "NO" for **all** of the years identified in *Question 2 and 3*, **DO NOT** answer Questions 4 and 5, nor Part II and Part III. **Proceed to Part IV and fill in the Certification information. Then return Part I and Part IV using the self-addressed label or envelope provided.**
- *For further information on this part of the questionnaire, please continue to page 5 of this booklet.*

Questionnaire Part II

- **NOTE:** Complete and return this part of the questionnaire only if you answered "YES" to any year in Part I, Questions 2, 3, 4, or 5, and you have offered a Group Health Plan (GHP) to any worker identified in Part III. Fill out information **only** on those GHPs that pertain to these workers.
- In Part II Page 1, we have provided a page with five pre-assigned GHP Report Numbers (0001-0005) and a second page with blank GHP blocks to record additional GHPs, if needed. **Each GHP identified must be given a single and unique report number.** Please use the first page for the first five GHPs and the second page for any additional plans.
- **NOTE:** Once you have assigned a Report Number to a particular health plan **that number CANNOT be used again** in this section of the report. These numbers should not be duplicated, since they are used to identify group health plans for workers identified in Part III. *For an example, see page 18 of this booklet.*
- Please provide the **complete** name, address (street name/number, city, state, and ZIP Code), Group ID Number or Code, Insurer/Third Party Administrator(TPA) Tax identification number (TIN) and only **one** GHP type, for each GHP listed.
- *For further information on this part of the questionnaire, please continue to page 6 and 7 of this booklet.*

Questionnaire Part III

- If you answer **"NO"** to *Question 1*, DO NOT CONTINUE. Proceed to the next individual's report.
- If you answer **"YES"** to *Question 1 or 2*, proceed to the questions that follow.
- If you answer **"NO"** to *Question 2*, provide the date the individual stopped working for your organization. If this date is prior to the date specified on the report, **STOP**, DO NOT CONTINUE. Proceed to the next individual's report. *For an example, see page 17 of this booklet.*
- If you answer **"NO"** to *Question 3*, **STOP**, DO NOT CONTINUE. Proceed to the next individual's report.
- For *Question 4a*, enter the **LATER** of the following:
  The date specified on the report;
  OR,
  The date that the individual **started** working for your organization.
- For *Question 4b*, enter the calendar date you provided in your answer to Question 2. If no date was given in Question 2, **enter the date you prepared this report.**
- In *Question 5*, report the group health plan coverage selected by the individual during the period between your answers to Questions 4a and 4b. Provide the beginning and ending dates for each period of coverage. Account for any period that the individual was not covered under a GHP by indicating a coverage elected of "NONE". *For an example, see pages 18 through 19 of this booklet.*
- **NOTE:** If the individual identified is or was covered by a collectively bargained health and welfare fund, go to **page 10** of this booklet for instructions on how to complete the answer to this question. The GHP Report number should match one of the GHP Report numbers from Part II of the report.
- *For further information on this part of the questionnaire, please refer to pages 7 through 10, for an example, see pages 18 through 19 of this booklet.*

Questionnaire Part IV

- It is essential that this section of the report is completed. Please indicate the name and title of the individual who is certifying this document.
- For further information on this part of the questionnaire, please refer to page 10, for an example, see page 20.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0565.

The projected burden for completing this report is dependent upon several factors. The number of individuals for whom you are requested to supply information has the largest impact on the paperwork burden. Other factors which may increase the burden are the accessibility and format of personnel and health plan records, the number of group health plans offered by the organization, and the frequency of changes between plans or in coverage elections. The projected average burden for completing this report (including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information) is as follows:

Number of Employees for Whom Information is Requested	Estimated Average Burden Hours
1	2
2 - 10	4
11 - 25	6
26 - 50	12
51 - 100	24
101 - 200	48
201 - 1,000	100
> 1,000	200

Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Center for Medicare Management
Benefits Operations Group / Division of Benefits Coordination
Mail Stop S1 - 05 - 06
7500 Security Boulevard
Baltimore, MD 21244-1850

and to:

Office of the Information and Regulatory Affairs
Office of Management and Budget
P.O. Box 26684
Baltimore, Maryland 21207

This information is being collected under contract (HCFA 500-00-0001) with the United States Department of Health and Human Services for use by the Medicare program.

Background Information:

Employer Group Health Plans and the Medicare Secondary Payer Program

Some people who have Medicare also have group health coverage. Usually, Medicare is their primary payer, which means that Medicare pays first on their health care claims. Sometimes, the other plan must pay first. In that case, Medicare is the secondary payer.

Until 1980, the Medicare program was the primary payer in all cases except those involving workers' compensation (including black lung benefits) or veterans benefits. Since 1980, new laws have made Medicare the secondary payer for several additional categories of people. The additional categories of people for whom Medicare is the secondary payer are described below.

Medicare Secondary Payer

Medicare secondary payer (MSP) is the term used by Medicare when Medicare is not responsible for paying first. (The private insurance industry generally talks about "coordination of benefits" when assigning responsibility for first and second payment.)

The terms "Medicare supplement" and "Medicare secondary payer" are sometimes confused. A Medicare supplement (Medigap) policy is a private health insurance policy designed specifically to fill in some of the "gaps" in Medicare's coverage when Medicare is the primary payer. Medicare supplement policies typically pay for expenses that Medicare does not pay because of deductible or coinsurance amounts or other limits under the Medicare program. An employer cannot offer, subsidize, or be involved in the arrangement of a Medicare supplement policy where the law makes Medicare the secondary payer. (See page iv on the IMPORTANT WARNING FOR EMPLOYERS).

Federal law takes precedence over conflicting State law and private contracts. Thus, for the categories of people described below, Medicare is secondary payer regardless of state law or plan provisions. These Federal requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)). Applicable regulations are found at 42 C.F.R. Part 411 (1990). You should verify that your group health plan is in conformity with these Federal documents. The official Federal requirements are contained in the relevant laws and regulations.

Who does MSP affect?

Medicare is now secondary payer to some group health plans (GHPs) or large group health plans (LGHPs) for services provided to the following groups of Medicare beneficiaries:

- The "working aged,"
- People with permanent kidney failure, and
- Certain disabled people.

As used in this booklet, a GHP/LGHP is:

- a plan that provides health care, either directly or indirectly through insurance or otherwise,
- provided to employees, former employees, or the families of employees or former employees, and contributed to or sponsored by an employer.

A GHP/LGHP includes those plans where employees pay all the costs.

The term *plan* includes insurance plans, prepaid arrangements, and self-insured plans. A plan can be any arrangement between one or more parties for the provision of health care. The arrangements may be oral or written.

Working Aged

The "working aged" are employed people age 65 or over and people age 65 or over with employed spouses of any age who have GHP coverage because of their or their spouse's current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

Medicare is secondary payer to GHPs for the "working aged" where **either**:

- a single employer of 20 or more employees is the sponsor of the GHP or a contributor to the GHP,

or

- two or more employers are sponsors or contributors, and at least one of them has 20 or more employees.

The "20 or more employees" threshold is met whenever an employer has 20 or more full and/or part time employees for 20 or more calendar weeks in the current calendar year or the preceding calendar year. This may be determined by the number of employees **on the payroll** on any given workweek. To illustrate; The ABC Corporation has 50 employees on its payroll every week. This consists of a staff of 10 full time employees who come in on Monday, Tuesday, and Wednesday and 40 part-time employees who only come in on Thursday and Friday. Due to the number of employees physically on the job for that calendar workweek, the ABC Corporation meets the 20 or more threshold.

When determining the "20 or more threshold," employers (i.e., individual or wholly owned entities) with more than one company must follow the IRS aggregation rules. In cases where an employer wholly owns more than one company, **all** employees of **all** the organizations in question are counted toward the 20 or more threshold. For example, the XYZ company has six subsidiaries. Each individual subsidiary has a total of 5 employees that worked 20 or more weeks for the calendar year. The 20 or more threshold is met with company XYZ because their number of aggregated employees total thirty. The relevant IRS codes can be found in 26 U.S.C. sections 52(a), 52(b), 414 (n) (2).

Medicare is the secondary payer regardless of how many employees are eligible to enroll or actually enroll in the plan.

For GHPs with more than one sponsoring or contributing employer, there are three possibilities:

- Where all of the employers have less than 20 employees, Medicare is primary payer for all working aged people enrolled in the plan because the plan is not subject to the MSP provisions.
- Where all of the sponsoring or contributing employers have 20 or more employees, Medicare is secondary payer for all working aged people enrolled in the plan.
- Where some of the sponsoring or contributing employers have 20 or more employees and some have less than 20, Medicare is secondary payer for all working aged people enrolled in the plan. There is one exception: a GHP may request to exempt those working aged people enrolled through an employer with fewer than 20 employees. If CMS approves the request, Medicare would become primary payer for specifically identified working aged people

enrolled through an employer with fewer than 20 employees. The GHP must be able to document its decision to exempt such individual. See page 3 of the instruction booklet, on how you can determine if this exclusion applies to your organization.

People with Permanent Kidney Failure
Medicare is secondary payer to GHPs during a 30-month coordination period for beneficiaries who have permanent kidney failure (End Stage Renal Disease), and who have coverage under a GHP on any basis (current employment status is not required as the basis for coverage).

Disabled People

Medicare is the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a LGHP based on the individual's (or a family member's) current employment status. In general, an individual has current employment status if the individual is an employee, the employer, or is associated with an employer in a business relationship.

A LGHP provides health benefits to employees, former employees, the employer, business associates of the employer, or their families, that covers employees of at least one employer with 100 or more employees.

Employer Responsibilities under MSP

Employers have a number of important responsibilities under the MSP law:

- To assure that their plans identify those individuals to whom the MSP requirements apply;
- To assure that their plans provide for proper primary payments when the law makes Medicare the secondary payer;
- To assure that their plans do not discriminate against employees and employee's spouses age 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is secondary payer; and,
- To timely and accurately complete data match reports on identified employees.

Working Aged

If you are an employer with 20 or more employees, your GHP must not discriminate against employees age 65 or over, or employees' spouses age 65 or over, whether or not they have Medicare. The benefits offered to these people under your plan must not differ in any way from the benefits offered to people who do not have Medicare. Your GHP must be primary payer for those benefits in MSP situations, and must not take into account working aged people's entitlement to Medicare.

GHPs must not, for example:

- fail to make primary payment, or make a smaller payment, on behalf of someone for whom Medicare is secondary payer,
- reduce or terminate coverage of employees and employees' spouses age 65 or over, either (1) because they have become entitled to Medicare, or (2) because they have attained age 65.
- refuse to allow employees and employees' spouses age 65 or over to enroll, or to re-enroll, on the same basis as younger employees and spouses,
- impose limitations on benefits, exclusions of benefits, or reductions in benefits on those age 65 or over that are not applicable to younger people who are enrolled in the plan, or
- impose higher premiums, higher deductibles or coinsurance, longer waiting periods, lower annual or lifetime benefits, or more restrictive pre-existing illness conditions for those age 65 or over than are applicable to those under age 65 who are enrolled in the plan.

You must inform employees and employees' spouses who are entitled to Medicare that they may reject coverage under the plan and choose Medicare as their primary payer. If they reject coverage under the employer plan, you may not offer them, facilitate or subsidize a plan intended only to supplement Medicare's benefits. Employer plans may, however, offer them coverage for items and services for which Medicare provides no benefits (for example, eyeglasses).

Beneficiaries who reject the employer plan may purchase Medicare supplemental (Medigap) coverage from some source other than the employer. The employer may not subsidize, purchase, or be involved in the arrangement of an individual supplement policy for the employee or family member.

People with Permanent Kidney Failure

For people who have Medicare entitlement or eligibility because of permanent kidney failure, during the first 30 months of that eligibility or entitlement, the GHP must be the primary payer. They may not take into account their eligibility or entitlement to Medicare based on permanent kidney failure.

The GHP must not, for example, fail to make primary payment or make a smaller payment on behalf of someone for whom Medicare is secondary payer.

In addition, the GHP must not discriminate against them because they have permanent kidney failure. The benefits provided must not differ in any way from the benefits provided to persons who do not have permanent kidney failure.

For all people with permanent kidney failure, with or without Medicare, both during and after the 30-month period, the plan may not:

- refuse to allow an individual with permanent kidney failure to enroll, or to re-enroll, in the plan, on the same basis as persons who do not have permanent kidney failure,
- fail to cover routine maintenance dialysis services or kidney transplants at the same level as other services covered by the plan when the plan covers other dialysis service or other organ transplants,
- impose limits on benefits, reduce benefits, or impose exclusions on enrollees who have permanent kidney failure that are not applicable to enrollees who do not have permanent kidney failure, or
- impose higher premiums, higher deductibles or co-insurance, longer waiting periods, lower annual or lifetime benefits, or more restrictive pre-existing illness conditions than are applicable to those who do not have permanent kidney failure.

Disabled People

A LGHP must not discriminate against disabled Medicare beneficiaries for whom Medicare is secondary payer. This means that it must not treat these people differently from other enrollees because they are disabled and have Medicare.

For example, with respect to these disabled Medicare individuals, a LGHP must not:

- fail to make primary payment, or make a smaller payment on behalf of someone for whom Medicare is secondary payer,

- terminate coverage on the basis of entitlement to Medicare,
- provide for different benefits, or a different level of benefits, on the basis of entitlement to Medicare, or
- charge a higher premium than it charges to other enrollees in the plan.

Employers must offer disabled Medicare beneficiaries the opportunity to reject the LGHP's coverage. In that case, Medicare becomes their primary payer, and the employer must not offer them, subsidize or be involved in the arrangement of supplemental (Medigap) coverage, except for items and services for which Medicare does not provide coverage (for example, eyeglasses).

However, as with the working aged, beneficiaries who reject the LGHP may purchase Medicare supplemental coverage, Medigap, from a source other than the employer, so long as the employer does not purchase, subsidize, or arrange for the coverage.

Making MSP Work

The health insuring organizations under contract to pay Medicare claims (Medicare carriers and intermediaries) are responsible to deny claims for primary benefits when Medicare is secondary payer. These contractors are also responsible for informing providers, employers, insurers and beneficiaries about MSP and how it works. Staff members from Medicare contractors give talks on MSP to hospital groups, insurance associations, beneficiary advocacy organizations and others. A representative of a Medicare contractor in your area would be happy to talk with you about MSP or any other Medicare issue you would like to discuss.

In making claims processing decisions, the Medicare contractors utilized information on the claim form and in the Medicare systems of records in order to avoid making mistaken primary payments. These payments are made by Medicare where a GHP or LGHP should properly be the secondary payer not the primary payer. In such cases, Medicare will not pay the claim as a primary payer and will return it to the claimant with instructions to bill the proper party.

Sometimes, after a Medicare claim is paid, a Medicare contractor gets new information that indicates Medicare made a primary payment by mistake. Based on this new information, the contractor seeks to recover the mistaken Medicare payment. Contractors will send initial demand letters for repayment to any or all the parties obligated to repay Medicare. These parties include the plan, employer, other plan sponsor, insurer, and third party administrator. The parties will be advised that it or its claims processor must take specified actions to resolve the repayment request.

If the parties do not directly (or arrange with its group health plan or claims processor to) refund the mistaken payment or provide the documented defense to the contractor as requested in the demand letter, the contractor refers the case to CMS.

CMS will review the case. CMS may refer the case to the Department of Justice for legal action if it determines that a properly documented defense or the required payment has not been provided. The law authorizes the Federal government to collect double damages from any party that is responsible for resolving the matter but which fails to do so.

CMS may also refer the case to a debt collection center or the Treasury Department for collection pursuit to the provision of the Debt Collection Improvement Act (DCIA). CMS may refer any or, all the parties that are responsible for payment for collection purposes. Under the DCIA, the government may take direct action to collect debt from any responsible parties or may also offset varies federal payments that may be due to any or all the parties against the outstanding debt.

CMS may also report employers that sponsor or contribute to GHPs that fail to follow MSP rules -- these are called "nonconforming group health plans" -- to the Internal Revenue Service (IRS). The IRS is required to impose a tax on the employers or employee organizations that contribute to these nonconforming plans. The tax is equal to 25 percent of all contributions the employer or employee organization made to all group health plans during the year. This tax provision is found in Section 5000 of the Internal Revenue Code (26 U.S.C. 5000).

IMPORTANT

WARNING FOR EMPLOYERS: CMS wishes to make sure that employers understand the legal consequences of purchasing directly or indirectly an individual Medicare supplemental (Medigap) policy for an employee or spouse of an employee. This arrangement that constitutes a GHP under Medicare law and the Internal Revenue Code. Employers must understand, that even if they do not contribute to the premium, but merely collect it and forward it to the appropriate individual's insurance company, the arrangement must be a primary payer to Medicare. In addition, the plan, because it takes into account the Medicare entitlement of the beneficiary, is also a non-comforming GHP which would subject the employer to possible excise taxes. If you have provided such coverage to a Medicare beneficiaries, we urge you to write to CMS, Office of Financial Management, Division of Financial Integrity to explain the situation and to take appropriate corrective actions.

Important Notice on Potential Health Insurance Costs Reduction (OBRA 93 Transition Process for Disabled Medicare Beneficiaries)

The Centers for Medicare & Medicaid Services is issuing this important alert to all employers. Specifically, this letter is to notify you that Medicare can become primary payer for certain disabled Medicare beneficiaries for whom your group health plan may currently be making primary payment. This means that your health insurance costs could be reduced.

HOW DOES THIS WORK?

Effective August 10, 1993, § 13562 of the Omnibus Budget Reconciliation Act of 1993 ("OBRA 93"), made Medicare the secondary payer for people under age 65 who have Medicare because of disability and who are covered under a large group health plan (LGHP) based on the individual's (or a family member's) current employment status. An individual has "current employment status" with an employer if he/she is an employee, is the employer (including self-employed persons), or is associated with the employer in a business relationship.

Prior to August 10, 1993, Medicare was also the secondary payer for a disabled individual who was under the age of 65, and who was also enrolled in a LGHP, if Medicare determined they were actively working for the employer despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period) or were not actively working but whom the employer treated as an employee. Medicare decided whether or not a person was an "active individual" as defined in the law. For this category of people Medicare is now primary

Because Medicare did not have information to distinguish whether disabled Medicare beneficiaries had that coverage based on current employment status, on July 14, 1994, CMS published a notice in the Federal Register, at 59 FR 35935, which explained procedures employers could use to transition their affected beneficiaries to the new rules.

WHY IS THIS AN ISSUE TODAY?

OBRA 93 did not authorize Medicare to compel employers to transition to the new rules. As a result, even after Congress changed the law, Medicare found that some employers chose to continue providing primary health coverage to some non-working disabled Medicare beneficiaries when not required to do so. However, recent events have indicated a need to provide you with more information.

We have become aware of several outside groups that have been soliciting employers by offering to manage the entire transition process for the employers. For a fee, these outside groups are offering to submit information to Medicare, on behalf of employers, so as to make Medicare the primary payer for those disabled Medicare beneficiaries that do not have coverage based on current employment status. We have also been receiving inquiries from employers, providers, and Medicare beneficiaries about retroactively applying the OBRA 93 change.

You may be unknowingly placing an unnecessary financial burden on both your company and these disabled Medicare beneficiaries if you are not fully informed of the following:

WHAT YOU SHOULD KNOW:

- Several of these outside groups that are soliciting employers are implying that they have a special relationship with Medicare or, in some instances, are implying that they are authorized to act on behalf of Medicare. These outside groups do not have any relationship to Medicare.

- Employers need not contract with any entity to transition the affected disabled Medicare beneficiaries to the OBRA 93 rules. An employer can make these changes directly with Medicare at no cost. The transition requirements are not complicated. Please call our Coordination of Benefits contractor at 1-800-999-1118 or (TTY/TDD) 1-800-318-8782 and they will give you more information.

- We understand that some employers are being encouraged to seek to make Medicare the primary payer retroactively to as early as August 10, 1993, and that employers are incorrectly being told that Medicare will make primary payments as far back as 1993. You should know that retroactive implementation may conflict with both your interests and affected disabled beneficiaries' interests. Also, because Medicare may pay only providers and suppliers of medical services, or in some cases, beneficiaries, and because Medicare has time limits for filing claims, you will not likely be able to recover payments as far back as 1993. To minimize your time and costs, and to protect the interest of the disabled Medicare beneficiaries, you may want to consider prospective changes rather than retroactive changes.

- You may be asked to sign a statement authorizing someone to act as an agent on your behalf. You should understand the legal consequences of such an appointment, so as not to create unintended results.

- If you decide to have someone act as your agent, you should be aware that the same agent may represent or seek to represent the disabled Medicare beneficiaries. This could pose a conflict of interest. We have been contacted by some beneficiaries who believe they were asked to sign open-ended appointments of representation or who believe that their best interests were not properly represented.

IF YOU DECIDE TO TRANSITION RETROACTIVELY

- Beneficiaries could be asked to pay Medicare Part B premiums back to the date they enrolled. This could amount to several thousand dollars for some beneficiaries. Conversely, your company may also be liable to your disabled employees for any employee contributions to your insurance plan if you are retroactively changing coverage. These changes could be administratively burdensome for you or your plan.

- Because Medicare primary payments are often less than private insurer primary payments, beneficiary out-of-pocket expenses could go up. Retroactive claims filing could create substantial costs for affected beneficiaries.

- The amount of primary payments that you may be able to recoup will be significantly limited by the following four factors. First, Medicare claims may only be submitted by providers and suppliers of the service, or in some instances, by the beneficiaries. Second, Medicare will not honor new claims if they are not submitted timely. Third, the time frame to reopen claims previously processed for secondary payment would, in most of these cases, be limited to one year from the date the Medicare secondary payment was determined. Fourth, physicians and suppliers that have already received primary payment from a private insurer may be unwilling or unable to refund that payment and bill Medicare.

- There may be additional costs to your company or plan, such as additional accounting and bookkeeping costs, related to making the change retroactive, as well as costs related to properly informing affected plan participants about their options for transitioning.

For further information, please call our Coordination of Benefits Contractor at 1-800-999-1118 or (TTY/TDD) 1-800-318-8782.

General Information:

How to Complete the Data Match Questionnaires

In late 1989, a law was enacted (Section 6202 of the Omnibus Budget Reconciliation Act of 1989) to provide CMS with better information about Medicare beneficiaries' group health plan coverage.

The law requires the IRS, the Social Security Administration (SSA), and CMS to share information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the IRS/SSA/CMS Data Match.

The purpose of the Data Match is to identify situations where another payer may be primary to Medicare.

The Data Match identifies employers of beneficiaries for whom employer coverage, if available, is likely to be primary to Medicare. The law requires that CMS contact these employers to confirm coverage information. Your compliance with this law will identify potential situations in which Medicare is not the primary payer.

This publication is intended to assist and guide you through the timely completion of the Data Match Project (DMP) Questionnaires, Parts I, II, III and IV. You should read through the entire instruction booklet and review your data match report before you begin to complete the report.

Depending on your organization's answers to the questions in Part I, it may not be necessary to complete Parts II and III. It is extremely important that all instructions are carefully and closely read and that all answers to the questionnaires provided by you are accurate. You should send the original questionnaires back to the designated address and keep a copy for yourself.

Applicable Federal MSP requirements are found in Section 1862(b) of the Social Security Act (42 U.S.C. Section 1395y(b)) and at 42 C.F.R. Part 411 (1990). You should verify that your group health plan is in conformity with these Federal requirements. This instruction booklet clarifies the procedures for completion of these questionnaires. However, it is not a legal document. The official Federal requirements are contained in the relevant laws, regulations, and rulings.

NOTE: *If you participate in a collectively-bargained health and welfare fund or a multiple employer plan, it may be necessary for you to contact the plan administrator to complete some of the sections of this report. Please do so early enough to assure that you will comply with the time frame stipulated in the law for completion of these questionnaires.*

For example, you may need to contact the plan administrator to find out if there is one employer in the plan that has or has had 20 or more full-time and/or part-time employees during the years listed on your data match report. Also, you would need to find out if there is one employer who has/had 100 or more full-time and/or part-time employees in any year listed on your data match report. DO NOT ask the plan administrator if there is/was an employer with 20 or 100 individuals eligible for coverage or covered under the plan. The requirements of the law are based on the number of employees, not the number of individuals eligible for coverage or covered under a plan.

This report may look different from other reports you are required to submit to the government. A major difference is that certain worker information has already been completed for you. This identified worker information is the result of the IRS/SSA/CMS Data Match process. You should note that these individuals were identified because either the worker or the worker's spouse is/was a Medicare beneficiary.

Any employer that has multiple Employer Identification Numbers (EINs) and would like all data sent to one central location for response may arrange for this. The request must be made in writing, to our post office box address noted below. Please inform all entities in your organization that you are making this request.

The law requires that you complete the enclosed report within 30 days. Employers who willfully or repeatedly fail to report, or who provide inaccurate or incomplete information, may be assessed a civil monetary penalty of up to $1,000 for each individual for whom an inquiry concerning health care coverage was made.

However, if you have thoroughly reviewed this instruction booklet and conclude that the information gathering and reporting will require more than the allotted 30 days, you may request an extension of an extra thirty days by calling our toll-free telephone number: 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.

Any request for an extension beyond these 60 days for filing will require you to detail the reasons in a letter written to:

Medicare – Coordination of Benefits
IRS/SSA/CMS Data Match Project
P. O. Box 125
New York, NY 10274-0125

In general, extensions beyond the 60-day period (the original 30 days and one 30-day extension) will not be granted to any employer who is required to report on less than 150 workers (Part III of the data match report). Extensions beyond the 60-day period for those employers with more than 150 workers wed on a case-by-case basis.

If you have more than 150 workers identified in Part III of your data match report and do not believe you can complete the report in 60 days, you should immediately request an extension over the phone and request an additional extension in writing. Your written request should contain the following:

- The name of your organization;
- The employer identification number (EIN) of your organization;
- Any associated EINs if you are a parent organization and wish to have all EINs aggregated; and,
- An explanation of the problem or difficulty that precludes completion of the questionnaire in 30 or 60 days and the actions you are taking to resolve the problem or difficulty.
- A proposed completion date.

NOTE: *The assessment of a civil monetary penalty will not relieve the employer of the requirement to provide this information.*

Definitions of Terms Used in these Instructions

The definitions listed below will help you to understand the terminology used in these instructions:

Employer: Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, the individual States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.

Group Health Plan (GHP): Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees. This includes plans where the employee pays all costs, i.e., through payroll deductions.

NOTE: *For the purposes of completing this report, the term "GHP" includes LGHPs (Large Group Health Plans).*

-see page ii for definition.

Third Party Administrator: A TPA is an entity that performs certain administrative functions of the GHP but does not provide insurance coverage.

An Insurer:
of a GHP is an entity that, in exchange for payment of a premium, agrees to pay for GHP covered services received by eligible individuals.

Worker Only Coverage: For the purposes of completing this report, "worker only" coverage is coverage that covers the worker, but not the worker's spouse. Worker and dependents other than spouse.

Family Coverage: For the purposes of completing this report, "family" coverage is coverage that covers both the worker and the worker's spouse. This does not include coverage that covers the worker and the worker's dependent child.

GHP Identification Number (or Code): This identifies the policy or contract number(s) under which workers are

covered for health insurance. Not all plans issue identification numbers.

Earliest Potential MSP (EPM) date: This is the pre-printed date referenced for each worker on the Part III form(s). It represents the date calculated as the earliest potential Medicare Secondary Payer (MSP) date for either the worker, or the worker's spouse. This date will vary for each worker.

NOTE: *See page ii for definition of MSP.*

Employer Identification Number (EIN): This is the number employers use when reporting employees earnings to the Internal Revenue Service (IRS). It is often referred to as the employer's Federal Tax Identification Number.

Employee: For purposes of the MSP provisions, an employee is an individual who works for an employer, whether on a full or part-time basis, and receives remuneration for their work. The employees (workers) identified in Part III of the data match report are individuals for whom a W-2 form was filed under your employer identification number.

Collectively-Bargained Health and Welfare Fund: Also referred to as a multi-employer health plan organized under a collective bargaining agreement. An "union" plan is an example of a multi-employer plan.

Multi-Employer Plan: These group plans involve arrangements with "collectively bargained health and welfare funds" (see above).

Multiple Employer Plan: A plan sponsored by two or more employers. These are generally plans that are offered through membership in an association or trade group. An example would be a local small business association who offers those employers who are members of the association the opportunity to purchase Group Health Plan coverage for their employees at a better rate because the employers have joined together to form a multiple employer plan.

Part-Time Employment: Part-time employment for a particular employer is less than whatever hours the employer considers to be full-time employment.

Civil Monetary Penalty (CMP): An amount of money that may be levied or assessed by the Federal government against an organization, corporation, company or individual for failure to comply with existing Federal statutes or laws.

Personal Identification Number (PIN):

This number appears on Part I, Page 1 of the Data Match Questionnaire. It is a 4 digit number that is used by employers to access the Data Match Bulletin Board Service (BBS). For further information on the BBS, please see page 11 of this booklet.

Tax Identification Number (TIN)

The vast majority of **GHPs** are separate legal entities with unique **TINS** or the **TIN** of the employer/sponsor with a unique suffix. Provide the unique **TIN** of the **GHP** you have identified. If you do not know the **TIN**, you may need to consult your financial officer.

If you need further clarification regarding terminology or other information, please call our toll-free number 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.

Instructions for Completing Part I

Question 1a: Did you offer a health plan to any employee at any time since (pre-printed date) ? (full or part-time)

Please answer either YES or NO, if any type of health plan was offered to full time and/or part time employees.

Question 1b: Did your organization make contributions on behalf of any employee who was covered under a collectively bargained Health and Welfare Fund (e.g. a union plan) since (pre-printed date) ?

Please answer either Yes or No if your organization makes contributions on behalf of any employee who was or is covered under a collectively bargained Health and Welfare Fund (e.g. a union plan).

NOTE: *If you answered NO to both questions 1a and 1b, you do not have to answer any of the other questions in Part I. Proceed to Part IV and fill in the Certification information. Return Parts I and IV using the self-addressed mailer or label provided.*

Question 2: In the following years, did you have 20 or more employees for 20 or more calendar weeks (this includes full time, part time, intermittent and/or seasonal employees)?

Please answer YES or NO as to whether there were 20 or more full and/or part time employees for 20 or more calendar weeks for each of the listed years (e.g., 1998, 1999, & 2000).

SPECIAL NOTE: If you are involved in a Multi-employer or Multiple Employer Group Health Plan, it may be necessary for you to contact your plan administrator in order to answer these questions. Employers must follow the IRS aggregation rules to determine whether the "20 or more threshold" is met, please refer to page ii of this booklet.

NOTE: *If there was a year listed in this report for either Question 2, 3, 4 or 5 for which you were not in business, please indicate NO for that year.*

Question 3: In the following years did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 20 or more employees for 20 or more calendar weeks (this include full time, part-time, intermittent and/or seasonal employees)?

For each of the years listed (e.g., 1998, 1999, & 2000), check YES or NO as to whether your organization participated in a multi- or multiple-employer Group Health Plan in which there was at least one employer who had 20 or more full and/or part time employees for 20 or more calendar weeks.

SPECIAL NOTE: For a definition of a Multi/Multiple Employer Plan, please refer to page 4 of this booklet **or call our toll-free number 1-800-999-1118 or (TTY/TDD): 1-800-318-8782.**

NOTE: *If you answered NO for all of the years identified in Questions 2 AND 3, you do not have to answer Questions 4 and 5. Fill in the Certification on Part IV and return Parts I and IV using the self-addressed mailer or label provided.*

Question 4: In the following years, did you have 100 or more employees during 50% of your business days full or part-time)?

Please answer YES or NO as to whether there were 100 or more full and/or part time employees during 50 percent of the business days during each of the listed years (e.g., 1998, 1999, & 2000).

Question 5: In the following years, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 100 or more employees during 50% of their business days (this includes full time, part-time, intermittent and/or seasonal employees)?

For each of the years listed (e.g., 1998, 1999, & 2000), check YES or NO as to whether your organization participated in a multi- or multiple-employer Group Health Plan in which there was at least one employer who has had 100 or more full and/or part time employees during 50 percent of the business days in the year listed.

NOTE: *If you answered YES to ANY of Questions 2, 3, 4, or 5, you will need to complete the remaining sections of this report.*

Some employers may be exempt from the MSP "working aged" rules if they are in a multiple or multi-employer plan. This exclusion may be applicable to your organization if you answered **NO** for each year listed in Part I, Question 2. You may wish to write to the multiple employer plan administrator and ask if the Multiple Employer Plan has requested and CMS has approved an exception to the Working Aged MSP rules that apply to your GHP. You should ask for a copy of the GHP's request and CMS's approval to be certain that you complete the questionnaire correctly. However, no exclusions can be made for End Stage Renal Disease beneficiaries or disabled beneficiaries. Please call the toll-free line (1-800-999-1118) and we will help you determine if your organization is eligible for the "working aged" exclusion.

Instructions for Completing Part II

If you answered YES for **any year** listed in Part I, Questions 2 through 5, you are required to complete Part II. You need to fill out information **only** on those Group Health Plans (GHPs) that involve workers identified in Part III of this questionnaire.

You **do not** need to complete information on any GHP offered by your organization if there are no workers identified in Part III that have or have had coverage under that GHP. You must include all GHPs under which a worker identified in Part III has or has had coverage during the time period identified for that worker.

The health benefit choices that you may offer to employees may consist of many different health plans and choices under each plan. Additionally, a particular health plan may have had different insurers or claims processors during the time period encompassed by this questionnaire. Each option should be listed as a separate group health plan, even though they all fall under the umbrella of your organization's group health plan.

For example, under an employer's benefit program, employees may select from 16 different GHPs. Some of the plans are fee-for-service while others are HMOs or PPOs.

Each option (fee-for-service, HMO/PPO) should be listed separately. In addition, if the GHPs are structured in a manner that hospitalization claims (e.g., major medical) are processed by one entity and medical services (e.g., physician services) are processed by a different entity, each should be listed as a separate GHP in Part II of the data match report

Group Health Plan Report Number

We are providing the following format so that you do not have to repeat the name and address of your GHP for each identified individual.

In the left-hand column of Part II Page 1 you will find the GHP Report Number. We have provided five pre-assigned GHP Report Numbers (0001-0005) and a second page with blank GHP blocks to record additional GHPs, if needed.

If you have had more than ten GHPs during the time period you are required to report**, you may make photocopies of the second page of part II, then number each additional GHP block in sequential order**.

For example, if your organization is required to report on all your GHPs since 07/01/1999 and there were 16 plans during that time, you must complete a block for each plan. The first GHP would be 0001, and the last would be GHP Report Number 0016.

Part II Page 1 and Part III of the forms cross-refer based on the GHP Report Number. Each worker identified in Part III should have a corresponding Part II GHP Report Number if he or she has/had a period of coverage. Only use GHP Report Numbers for workers identified in Part III. If no workers identified in Part III use a GHP that you offer, do not include that GHP in Part II.

Group Health Plan Name

Provide the name of your plan, e.g., XYZ Insurance, VIP Health Insurance of the United States, ABC HMO, Union Local #198 Health Plan, etc.. If your GHP is a third-party arrangement, please provide the name of the third-party administrator. Only use the name of your organization in this block if your plan is self-insured **and** self-administered.

Group Health Plan Address

Provide the mailing address of your GHP including street or PO Box, City, State and ZIP Code as shown in the following example. Please make sure that this address is the address where claims are actually filed for covered individuals, not just the corporate office of the GHP.

Group Identification Number or Code

Provide the group identification number or code of the GHP as shown in the following example. Not all GHPs supply identification numbers. If you do not have an ID number for a particular GHP, please leave this space blank.

IMPORTANT NOTE: If the plan you have listed is organized as a Third Party Administrator (TPA) arrangement under a contract such that the TPA provides **only** administrative services related to claims processing, please provide the date the entity listed ceased to be your claims administrator in the space you also have listed the Group Identification Number or Code. If the entity continues to be your claims administrator, please do not provide a date. A date is required only for TPA arrangements that DO NOT involve reinsurance, stop-loss, or minimum premium. Remember, you still are required to complete "Type of GHP".

GHP Tax Payer ID No.

Provide the TIN of the group health plan. The vast majority of GHPs are separate legal entities with unique TINs or which use the TIN of the employer/sponsor with a unique suffix. You need to provide the TIN of each GHP..

Type of GHP

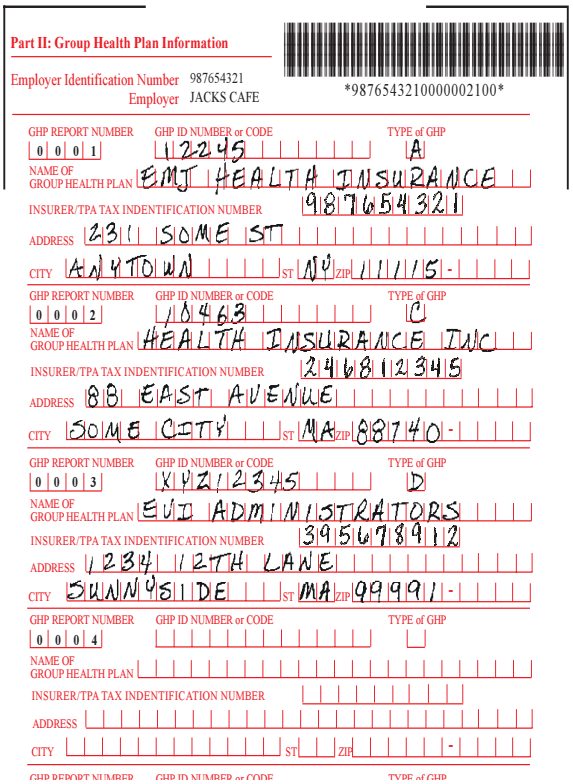
For each GHP Report Number, please identify, by a letter from the following table, the type of plan that best describes the GHP arrangement provided by your organization. The options are:

A. Insurance (Medical and Hospital)
B. Health Maintenance Organization (HMO)
C. Preferred Provider Organization (PPO)
D. Third Party Administrator arrangement under an Administrative Services Only (ASO) contract without stop loss insurance from any entity
E. Third Party Administrator arrangement with stop loss insurance from any entity.
F. Self-Insured/Self-Administered
G. Collectively-Bargained Health and Welfare Fund
H. Multiple employer health plan with at least one employer who has more than 100 full-time and/or part-time employees
I. Multiple employer health plan with at least one employer who has more than 20 full-time and/or part-time employees
J. Hospitalization only plan -- A plan which covers **ONLY** inpatient hospital services. (e.g., indemnity benefit plans)
K. Medical Services only plan -- A plan which covers **ONLY** non-inpatient medical services.
M. Medicare supplemental plan, Medigap, Medicare wrap-around plan or Medicare carve-out plan.

NOTE: Please do not include retirement/ pension plans, life insurance plans, prescription drug plans, dental plans, and or special purpose indemnity benefit plan (e.g., cancer plans).

Example

The example to the right provides completed Part II Page 1 information. This employer had three different Group Health Plans which are being identified by GHP Report 0001, 0002, and 0003. The first GHP, EMJ Health Insurance plan, is identified as GHP Report Number 0001. The address, GHP ID Number or Code and Type of GHP are all provided in their appropriate boxes in the first section. Similarly, the other two Group Health Plans are identified in the remaining lines.



Part II: Group Health Plan Information

Employer Identification Number 987654321
Employer JACKS CAFE

98765432100000021000

GHP REPORT NUMBER	GHP ID NUMBER or CODE	TYPE of GHP
0001	12245	A

NAME OF GROUP HEALTH PLAN: EMJ HEALTH INSURANCE
INSURER/TPA TAX INDENTIFICATION NUMBER: 987654321
ADDRESS: 2311 SOME ST
CITY: ANYTOWN ST: NY ZIP: 11115-

GHP REPORT NUMBER	GHP ID NUMBER or CODE	TYPE of GHP
0002	10463	C

NAME OF GROUP HEALTH PLAN: HEALTH INSURANCE INC
INSURER/TPA TAX INDENTIFICATION NUMBER: 246812345
ADDRESS: 88 EAST AVENUE
CITY: SOME CITY ST: MA ZIP: 88740-

GHP REPORT NUMBER	GHP ID NUMBER or CODE	TYPE of GHP
0003	XYZ12345	D

NAME OF GROUP HEALTH PLAN: EUI ADMINISTRATORS
INSURER/TPA TAX INDENTIFICATION NUMBER: 395678912
ADDRESS: 1234 12TH LANE
CITY: SUNNYSIDE ST: MA ZIP: 99991-

GHP REPORT NUMBER	GHP ID NUMBER or CODE	TYPE of GHP
0004		

NAME OF GROUP HEALTH PLAN:
INSURER/TPA TAX INDENTIFICATION NUMBER:
ADDRESS:
CITY: ST: ZIP:-

Instructions for Completing Part III

You will be supplied with the name and social security number (SSN) of each individual for whom you are required to furnish the requested information.

You are requested to provide information on this Part III form as of a defined date that is unique to each worker. The calculation of this date took into account all applicable MSP laws and regulations.

NOTE: This date will vary for each worker.

For **Question 1**, the records indicate that this individual was employed by your organization during the years specified. Please answer either YES the individual was employed, or NO the individual was not employed during any of the specified years.

SPECIAL NOTE FOR RELIGIOUS ORDERS: Members of religious orders that have taken a vow of poverty are exempt from the MSP provisions. **This exemption is only applicable for work being performed for the religious order.** For further information on religious order exemptions, please call our toll-free line. If the noted employee **has** taken a vow of poverty, answer 'NO' to question 1. Do not continue, proceed to the next individual's report.

If you answer NO to this question, DO NOT CONTINUE. Proceed to the next individual report. If there are no more individual reports, go to Part IV. Sign the Certification Statement and return the questionnaire using the self-addressed mailer or label provided.

Example (Question 1):

1. Was this individual employed by your organization during **1999 or 2000**? ☒ YES ☐ NO

- STOP **If the answer to Question 1 is NO, Go to the next individual's report.**

For **Question 2,** information is requested regarding whether this individual is currently employed by your organization. Check the appropriate box (YES or NO). If the answer is NO, please provide the date the individual stopped working for your organization.

IMPORTANT NOTE: If the individual listed on the report is a re-employed retiree, a seasonal, temporary, intermittent employee, please contact the toll-free line on how to complete Part III, Questions 1 to 5. *There is a line directly under Question 2. If the individual listed stopped working for your organization BEFORE THE DATE LISTED in this line, DO NOT CONTINUE.*

Proceed to the next individual report. If there are no more individual reports, go to Part IV. Complete the Certification, sign, and return the questionnaire using the self-addressed mailer or label provided.

Example (Question 2):

2. Is this employee currently working full or part-time in your organization? ☐ YES ☒ NO
   If the answer to Question 2 is **NO,** enter the date the individual stopped working for your organization (full or part-time) here.

Month: 05	Day: 01	Year: 2000

STOP **If this individual stopped working for your organization before *01/01/1999 DO NOT complete Question 3 to 5**

***Note:** The date given in the above example represents **this** individual's, *and only this individual's* EPM (Earliest Potential Medicare Secondary Payer) date. This date will vary for each worker and also appears in Question's 2,3, and 4.

In the above example, Mr. Steven Grant worked for the Ace Tire Company from 01/01/1999 (Mr. Grant's EPM date) to 05/01/2000. The last date of employment for Mr. Grant was 05/01/2000. This is the date that should be used as the answer to Question 2.

The individual may have stopped and started working several times during the Data Match reporting period. For the purpose of answering Question 2, please provide the most recent date on which the individual stopped working for your organization.

For **Question 3,** information is requested regarding coverage of the individual under a Group Health Plan (GHP) at any time after the specified date. An example appears below.

There is a line directly under Question 3. If the individual listed was not covered under your Group Health Plan AFTER the date listed in this line, DO NOT CONTINUE. If you answer NO to this question, proceed to the next individual report. If there are no more individual reports, go to Part IV. Complete the Certification and return the questionnaire using the self-addressed mailer or label provided.

Example (Question 3):

3. Was this individual covered under a Group Health Plan at any time after **01/01/1999?** ☒ YES ☐ NO

- STOP If this individual was not covered under a GHP after 01/01/1999, DO NOT complete Questions 4 or 5.

Mr. Alfred Green has been employed with Allstate Construction since 08/15/1998 In every year since then, he has been covered under the company's Group Health Plan. Since Mr. Green's coverage continued after the date given, 01/01/1999, the answer to Question 3 would be "YES".

Note: The pre-printed date in question 3 may be different for each worker. Please refer to each individual's unique pre-printed date before answering this question.

Question 4a asks you to fill in the **LATER** of (1) the date specified on the report, or (2) the date which the identified individual started working for your organization. If the individuals start date is **after** the pre-printed date given, use the date they started working. If they started working **prior** to the date given, use the pre-printed date on their form.

For **Question 4b**, please enter the information given in your answer to Question 2. This would be the month, date, and year the individual stopped working for your organization. If the individual is currently working, please use the date that you prepared this report.

Example (Question 4a and 4b):

4. Please enter in the box marked 4a below, the LATER of **01/01/1999** or the date this individual started working for your organization. In box 4b, enter your answer from Question 2. If still currently employed, use current date.

4a. Month: 01	Day: 01	Year:1999	4b: Month: 10	Day: 01	Year:2000

In the above example the period of employment for Ms. Grey in Question 4a to 4b was 01/01/1999 to 10/01/2000. In 4a the employer provided the later of the date Specified (01/01/1999) or the date Ms. Grey started working for Ace Pharmacy Company (03/15/1987). The date Ms. Grey stopped working (10/01/2000) is the date provided in 4b. This date also corresponds with the date entered in Question 2.

For **Question 5**, information is being sought regarding the type of GHP coverage the individual had or still has during the period between your answer to Question 4a and Question 4b.

In question 5, you will find a table with periods 1 through 8. Separate periods are given on this form because the coverage elected by the employee may have changed several times between the answers to questions 4a and 4b.

"Coverage Elected" Definitions:

Worker Only: The worker is the only individual covered under the GHP.

Family Coverage: The worker and the spouse are covered under the GHP, indicate family coverage.

SPECIAL NOTE: However, if you have certain knowledge that the covered dependent(s) is someone other than a spouse (e.g., a dependent child), please indicate "Worker Only" coverage. The coverage elected by the worker MUST be indicated for each period of coverage.

In this section, you will find a table with period numbers 1 through 8. If you need more than eight spaces (if the employee had more than eight types of coverage during the time period), **please photocopy this form BEFORE completing Question 5.** Indicate that additional periods of GHP coverage were required, by checking the box marked "Please check here ☐ if this sheet is a continuation page from the original Part III form for this employee."

It is recognized that in some situations, employees will leave employment for periods of time or be laid off and then return to work. These periods should be accounted for in your answer to Question 5. During any interval when the employee was not covered by a GHP, the coverage elected should be indicated as "NONE". List each period of coverage or non-coverage in chronological order.

Please provide information ONLY for the time between your answer to Question 4a and Question 4b.

Example (Question 5):

5. During the period of time between your answer to Question 4a and your answer to Question 4b, what type of health coverage did this individual elect under your plan? If the individual is still employed by your organization, please complete the following from the date listed in Question 4a to the date in 4b.

Period	Beginning Date	Ending Date	Coverage Elected (check one box)			GHP Report Number
			Worker Only	Family (Worker & Spouse)	None	
1	01/01/1999	02/29/2000	X			0002
2	03/01/2000	10/01/2000		X		0002

In the previous example, Ms. Grey had two periods of coverage during the period of time between 01/01/1999 and 10/01/2000 (i.e., the responses to Questions 4a and 4b). The first period was from 01/01/1999 to 02/29/2000. During this period, Ms. Grey elected a 'Worker Only' policy. When Ms. Grey married on 03/01/2000, she elected to change her coverage to 'Family', but the group health plan remained the same. As indicated above, her second period of coverage shows from 03/01/2000 to the date Ms. Grey stopped working (i.e., 10/01/2000).

Example (Question 5, when there was a period of no GHP coverage):
You must report the coverage selected by each individual for each period of time. Account for any periods that the individual was not covered by indicating coverage elected as "NONE".

Period	Beginning Date	Ending Date	Coverage Elected (check one box)			GHP Report Number
			Worker Only	Family (Worker & Spouse)	None	
1	01/01/1999	07/31/1999		X		0001
2	08/01/1999	12/31/1999		X		0002
3	01/01/2000	05/31/2000			X	
4	06/01/2000	02/08/2001		X		0003

In the above example, Mr. Kelly had four periods of coverage identified. For the first period (01/01/1999 to 07/31/1999) he elected 'Family' coverage under the group health plan indicated as 0001 on Part II of the questionnaire. The second period (08/01/1999 to 12/31/1999) shows that he changed his GHP to 0002. Mr. Kelly then elected a period of 'No' coverage (from 01/01/2000 to 05/31/2000) represented by the "**X**" placed in the 'None' column. Then, on 06/01/2000, he elected 'Family' coverage, with GHP report number 0003, to the present date (which in this case, is indicated as 02/08/2001). All periods between 01/01/1999 (Question 4a) and 02/08/2001(Question 4b) are accounted for in this response.

Example (Question 5, showing coverage under a Collectively-Bargained Health and Welfare Fund):

1	01/01/1999	10/01/2000	?	?	?	0004

If the coverage of an employee is through a collectively-bargained health and welfare fund, you as an employer may not know the dates of coverage or type of coverage the employee elected under the health plan. Therefore, for those employees covered under these type of plans, you may complete Part III, Question 5 as follows:

- For the beginning and ending dates of coverage, enter your answers from Question 4.
- Annotate "Coverage Elected" using a question mark (?).
- Enter the GHP Report Number assigned by your answers in Part II of the report.
- The name and address of the collectively-bargained health and welfare fund should be listed in Part II.

Important Note:

As the employer, you are responsible for following up with the health and welfare fund to obtain the required information. However, if you elect to respond using the question marks as in the example above, we shall assume that the coverage elected is Family.

Instructions for Completing Part IV

The individual responsible for completing the questionnaire must sign and date Part IV, also neatly printing or typing the person's name, title, and daytime telephone number.

Make sure the Privacy Act Statement is fully reviewed and understood. After the report is complete, please return the questionnaire using the self-addressed mailer or label provided, or mail to:

Medicare - Coordination of Benefits
IRS/SSA/CMS Data Match Project
P.O. Box 125
New York, NY 10274-0125

Thank you in advance for your cooperation. If you have any questions concerning the completion of the forms, please call:

1-800-999-1118 or

(TTY/TDD): 1-800-318-8782

This toll-free number is available from 8:00 a.m. to 8:00 p.m. (Eastern Time), Monday through Friday.

Information on the Bulletin Board Service

Employers who are required to complete a questionnaire for less than 500 workers may now choose to submit their responses through the Data Match Bulletin Board Service (**BBS**). This easy to use personal computer (**PC**) based feature allows employer's to download a customized application and respond to the complete Data Match questionnaire with the use of a dial up modem.

WHAT IS A BBS ?

The **BBS** is a system that users dial up over telephone lines with computers and modems. It may be used to receive or send files and messages from the users. In addition, users may be able to receive files or messages from a **BBS** system.

GETTING STARTED

System Requirements

You must have an IBM PC or compatible running under Windows 95, 98 or NT, a modem (56K bps or higher) and a communication program to operate your modem. We strongly recommend using WINDOWS HYPERTERMINAL..

The recommended communication parameter settings are as follows:

8-N-1	8 data bits, no parity, 1 stop bit
ANSI	Terminal Emulation
FULL Duplex	Don't use half duplex
XON/xoff = off	No software flow control
RTS/CTS = on	Enable hardware flow control
Auto-LF = off	Do Not translate a <CR> <LF>
BS = destructive	The <Backspace> keystroke should erase what it moves over
Transfer Protocol	Z-Modem

We also recommend that the following disk space allocations be made for storing and executing the BBS program:

8MB disk storage space & 2MB RAM

Signing Up for the BBS

First, notify our office of your decision to use the BBS by calling our toll free number (1-800-999-1118 or TTY/TDD: 1-800-318-8782) and utilizing the Audio Response Unit (ARU). The ARU is an interactive automated referral mechanism that processes requests for information in regards to the Data Match Project with the use of a touch tone telephone.

The ARU will furnish general information on the Bulletin Board Service as well as the option of registering for this service. If after listening to the electronic media information and specifications you decide to submit responses through the BBS, you can record your decision by selecting the appropriate menu option.

When selecting the menu option "to register for the BBS" you will be prompted for your employer identification number (EIN) and 4-digit personal identification number (PIN). These numbers can be retrieved from Part I, page 1 of the questionnaire or the EMQ Election Form. The combination of the EIN/PIN number will also serve as your password when utilizing the BBS. You may dial into the BBS for your company's questionnaire data after five business days.

IMPORTANT NOTE:

1) All **new** users dialing into the BBS will have to register as a user.
2) After registering as a new user, you will need to call the BBS System Operator, SYSOP, at (646) 458-6633 or (646) 458-6678 to activate your account before you can download from the BBS.

Logging Onto BBS

Five days after registering to use the BBS, dial into the BBS at **(646) 458-6785.** After entering your EIN and PIN, you can begin downloading the questionnaire data, including a customized editing program. The program will feature interactive prompts, on-line edits and a help facility to ensure that all the required data is correctly provided.

Downloading Data from the BBS

The entire downloading of the application may take between 45-60 minutes. Please note that this time frame is dependent upon the size of your questionnaire file **and the speed of your modem**. Once the program has been downloaded to your PC, disconnect from the BBS and execute the program on your PC.

For Users Who Have the BBS Application from the Previous Data Match Project:

Step 1:

Make a backup copy of last year's DATAFILE.TXT (1998) before beginning to download the new DATAFILE.TXT for this project year (2000).

Step 2:

Delete the old DATAFILE.TXT from your download folder.

Step 3:

Select "DOWNLOAD INPUT FILE" from the BBS Menu. This is your new DATAFILE.TXT. Be sure to place this in the same folder as the existing BBS Executable Application file, BBSV1.EXE, that you downloaded from the previous project.

Step 4:

Download the file, disconnect from the BBS, and execute the program on your PC.

For New Users of the BBS Application:

Step 1:

On the BBS Menu, select "DOWNLOAD INPUT FILE" to download the DATAFILE.TXT. Then select "DOWNLOAD BBS APP" to download the BBS Executable Application file. You will need to download these files separately but place them in the same download folder.

Step 2:

Disconnect from the BBS and execute the program on your PC.

Once the application has been successfully executed on your PC, the following steps should be taken:

Step 1:

Review the HELP Section on the Toolbar if you are not familiar with the BBS. This option contains instructions on how to utilize the bulletin board service.

Step 2:

The questionnaire data must then be loaded. To load the data:

- Select File from the main menu bar. A pull down menu will appear. Select Load Data from the list of menu options.

Step 3:

Once the questionnaire data is loaded you may proceed to Part I - Employer Information. Please note that all of Part I must be completed before you can continue.

Step 4:

After Part I is complete, dependent upon the responses provided, Part II - Group Health Plan Information will need to be completed.

Step 5

When Part II is complete, please proceed to Part III - Employee Information.

Step 6:

A verification must be run after Part I - III have been completed. Verify validates every data element entered for completeness and consistency. To execute the verification process:

- Select File from the main menu bar. When this is done a pull down menu will appear.
- Go to Verify. Another submenu will appear. From this menu select Run Verify.
- If any errors are detected go to step 7. However, if no errors are identified you may proceed to step 9.

NOTE: *All errors must be corrected before data can be uploaded to the BBS*

Step 7:

- If you would like to review the errors detected through the verification process, a report may be run. To run a report:
- Follow step 6 above. However, instead of selecting Run Verify the appropriate option would be Display Report.

Step 8:

After all the applicable sections of the report have been completed the next step is the certification (Part IV).

Step 9:

A backup copy of your report should be made before it is returned to the Data Match Contractor. To process a backup:

- Select File from the main menu bar. A pull down menu will appear. Backup will be listed as one of the menu options. Once it is selected a backup will be made of your questionnaire response file.

Step 10:

After steps 1 through 9 have been successfully accomplished, the completed report may be sent back through the BBS to the Data Match Center. To send data:

- Select File from the main menu bar. A pull down menu will appear. Create File will be listed as one of the menu options.

Please consult this booklet for more explicit instructions and samples on how to complete the various parts of the Data Match Questionnaire.

Uploading Data to the BBS

When you have completed all the questionnaires, dial back into the BBS to upload your data. The same EIN and PIN combination that was utilized to initially access the BBS must be entered to upload the completed data. You may dial in at any time. The service is available 24 hours a day, seven days a week.

WHY USE THE BBS?

It is simply a more convenient way to submit the Data Match Questionnaire. The BBS will also minimize the need for follow up, because the customized program provides an on-line editing feature that checks your responses for completeness and consistency.

If you require assistance once you have entered the BBS, or you experience any technical problems, contact our Electronic Media Department at (646) 458-6633 or (646) 458-6678.

42 USC 1395y(b)(5)
Identification of Secondary Payer Situations

(A) REQUESTING MATCHING INFORMATION. –

(i) COMMISSIONER OF SOCIAL SECURITY. -- The Commissioner of Social Security shall, not less often than annually, transmit to the Secretary of the Treasury a list of the names and TINs of Medicare beneficiaries (as defined in section 6103(l)(12) of the Internal Revenue Code of 1986) and request that the Secretary disclose to the Commissioner the information described in subparagraph (A) of such section.

(ii) ADMINISTRATOR. -- The Administrator of the Health Care Financing Administration (renamed Centers For Medicare & Medicaid Services 6/14/01) shall request, not less often than annually, the Commissioner of the Social Security Administration to disclose to the Administrator the information described in subparagraph (B) of section 6103(l)(12) of the Internal Revenue Code of 1986.

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS. -- In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the Secretary may designate) the information received under subparagraph (A) for the purposes of carrying out this subsection.

(C) CONTACTING EMPLOYERS. --

(i) IN GENERAL. -- With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(D)(iii) of such Code), as disclosed under subparagraph (B), the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

(ii) EMPLOYER RESPONSE. -- Within 30 days of the date of receipt of the inquiry, the employer shall notify the intermediary or carrier making the inquiry as to the determinations described in clause (i). An employer (other than a Federal or other governmental entity) who willfully or repeatedly fails to provide timely and accurate notice in accordance with the previous sentence shall be subject to a civil money penalty of not to exceed $1,000 for each individual with respect to which such an inquiry is made. The provision of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).